

Project #

Participant Feedback Survey

OMB NO. 0930-xxxx
Expiration Date xx/xx/xxxx

Today's Date (mm/dd/yyyy)

This anonymous form will help community leaders learn about needs in our community, and about how well the crisis counselors/outreach workers are meeting these needs. Please do not put your name on this form. If you filled out a form like this in the past week, please do not fill out this one. We thank you very much for your time!

How good of a job did the counselor or outreach worker do . .

	Extremely poor (1)	Poor (2)	Fair (3)	Good (4)	Excellent (5)
Treating you with respect?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respecting your culture, race, ethnicity, or religion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making you feel that asking for help is okay?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making you feel that you can help yourself and your family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keeping things you said private?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please indicate below which program services you have used. If you have used the service, please indicate whether or not it was helpful to you.

	Have you used this service?		Was this service helpful?	
	Yes	No	Yes	No
One-to-one interaction (with counselor/outreach worker)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Public education presentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Group counseling/support group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Handouts/materials	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Internet sites (Crisis Counseling Assistance and Training Program [CCP] website, Facebook, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Referral resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have used referral resources, which types(s) did you utilize?

Substance use

Mental health

CCP services

Community services (e.g., Federal Emergency Management Agency, loans, housing, employment, social services)

Resources for those with disabilities or other access or functional needs

Other referral type (Please specify type:_____)

How good of a job did this program do with . . .

Helping you to know that your feelings after the disaster were the same as many other people's feelings?

Helping you to find ways to take care of yourself, like eating right and getting enough sleep?

Helping you to stay active in things like hobbies, sports, church, or volunteer work?

Extremely poor Poor Fair Good Excellent

(1) (2) (3) (4) (5)

(1) (2) (3) (4) (5)

(1) (2) (3) (4) (5)

In general . . .

How good was the information you got on how people feel after disasters?

How good of an idea is it to tell a friend who was upset by the disaster to see this counselor or outreach worker?

Extremely poor Poor Fair Good Excellent

(1) (2) (3) (4) (5)

(1) (2) (3) (4) (5)

Not at all useful Slightly useful Moderately useful Very useful Extremely useful
(1) (2) (3) (4) (5)

How useful was this program in helping return things in your life back to the way they were before the disaster?

Overall, how useful was this program to you?

People experience disasters in a variety of ways. Below is a list of experiences you may have had. Please select all that apply to you.

My family member is missing or dead.

My friend is missing or dead.

My pet is missing or dead.

My home is damaged or destroyed.

I had major property loss, such as car/vehicle loss.

I had other financial loss.

I or a member of my household was injured or physically harmed.

My life or that of someone in my household was threatened.

I or a member of my household witnessed death/injury.

I or a member of my household assisted with rescue/recovery.

I am or a member of my household is unemployed because of this disaster.

I was evacuated quickly with no time to prepare.

I had prolonged separation from family.

I was displaced from my home for 1 week or longer.

For the questions below, please share your reactions (feelings, emotions, and thoughts) about the disaster, considering your reactions in THE PAST MONTH. Using a scale of 1 to 5, where 1 is not at all, 2 is a little bit, 3 is somewhat, 4 is quite a bit, and 5 is very much, in the past month to what extent have you . . .

	Not at all (1)	A little bit (2)	Somewhat (3)	Quite a bit (4)	Very much (5)
Been bothered by bad memories, nightmares, or reminders of what happened?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tried NOT to think or talk about what happened or to do things that remind you of what happened?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been bothered by poor sleep, poor concentration, feeling jumpy or angry, or being scared that something else bad will happen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been down or depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Found other stressful things harder to deal with because of what happened?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had trouble taking care of your health (e.g., eating poorly, not getting enough rest, smoking more, drinking more)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had difficulty getting along or having fun with family and friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Needed help from a counselor to deal with your reactions to the disaster?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you would like to speak with a counselor about your reactions or if you have concerns about your answers to these questions, please call xxx-xxx-xxxx.

Comparing your emotional and mental well-being before the disaster to now, do you feel better, worse, or about the same?

Feel better now Feel about the same Feel worse now

Comparing how well you take care of your health before the disaster to now, do you take care of your health better, worse, or about the same?

Take care of your health better now Take care of your health about the same now Take care of your health worse now

Comparing how well you work (including a job, schoolwork, and housework) before the disaster to now, do you have less trouble working, more trouble working, or about the same amount?

Have less trouble working now Have about the same amount of trouble working now Have more trouble working now

Comparing how active you were in things like hobbies, sports, church, or volunteer work before the disaster to now, are you more active, less active, or about the same?

More active now About the same Less active now

PLEASE ALSO ANSWER QUESTIONS ON THE BACK.

The final questions will help us to describe the total group of people who completed the form.

How do you identify yourself? Male Female

In what year were you born? _____

What is the highest level of education you have completed or degree you have received?

- | | |
|--|---|
| <input type="checkbox"/> 0-6 years | <input type="checkbox"/> Some college |
| <input type="checkbox"/> 7-11 years | <input type="checkbox"/> College graduate or more |
| <input type="checkbox"/> 12 years (high school diploma or GED) | |

In what county or parish do you currently live? _____

Are you Hispanic/Latino? Yes No

Which of the following best describes your race? (Please select all that apply.)

- | | |
|--|---|
| <input type="checkbox"/> Asian or Pacific Islander | <input type="checkbox"/> American Indian or Alaska Native |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> White or Caucasian |
| <input type="checkbox"/> Other (Please specify): _____ | |

What is your preferred language? English Spanish Other (please specify): _____

If you have a disability, or other access or functional need, please indicate the type (select all that apply).

- | | | |
|---|---|--|
| <input type="checkbox"/> Physical (mobility, visual, hearing, etc.) | <input type="checkbox"/> Intellectual/Cognitive (learning disability, mental retardation, etc.) | <input type="checkbox"/> Mental Health/Substance Use (psychiatric issue, substance dependence, etc.) |
|---|---|--|

Thank you for taking time to complete this form!

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0930-0270. Public reporting burden for this collection of information is estimated to average 15 minutes per participant per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, MD 20857.